Hypnotherapy in palliative care

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SUMMARY

Complementary therapies have found increasing vogue in the management of patients with cancer, although little formal evaluation has been undertaken. We report on our experience of offering hynotherapy to palliative care outpatients in a hospice day care setting.

During $2\frac{1}{2}$ years, 256 patients had hypnotherapy, all singly; two-thirds (n=104) were women. Only 13% (n=21) had four or more treatment sessions. At the time of survey, the 52 patients still alive were mailed an evaluation sheet, of whom 41 responded. 61% reported improved coping with their illness. 7% (n=3) reported harmful or negative effects from hypnotherapy. Amongst those whose coping was unchanged, many found the therapy a pleasant experience. 35 respondents (85%) appended positive comments to their questionnaire returns.

Despite the limitations of a retrospective questionnaire, our findings suggest that hypnotherapy, used within strict guidelines in patients with advanced cancer, is a safe complementary therapy to enhance coping.

INTRODUCTION

Hypnotherapy has been used in the management of various psychological disorders such as post-traumatic stress disorder[1,2], insomnia[3] and acute panic attacks[4]. It has also been widely advocated for the treatment of addictions, particularly tobacco addiction[5–7]. To control acute painful episodes, such as occur in children with malignancy[8], labour[9], and dressing of burns[10] or to control chronic pain in benign disease[11,12] and malignancy[13], patients can learn self hypnosis techniques to use during painful episodes, with or without assistance from the therapist[14]. Trials are difficult to conduct, but similar results have been shown with cognitive therapies[15]. Hypnotherapy has been reported as useful in symptom control and for distress in terminal care[16].

Hypnosis has recently become disreputable; false claims for its results have been made and a trance-like state induced in subjects has been abused for public entertainment. However, it is not possible to hypnotize patients against their will.

The hypnotic change in state of mind is far more akin to intense concentration than to sleep[17], and its effect on pain may be by neurophysiological modification of pain signals by brainstem mechanisms[18,19].

A hypnotic state may be induced by relaxation routines, particularly when visualization is also used. Many hospice services offer relaxation and visualization as part of their complementary therapy armamentarium, without being aware that the therapist may be inducing a trance-like state of suggestibility in some individuals, particularly those who are easily hypnotized[20,21]. During this state of suggestibility the patient can be taught to regain control over manifestations of anxiety, and encouraged to feel empowered to abandon fears and addictions, and to undertake diversional thinking from unpleasant somatic experiences such as pain[22–24].

BACKGROUND

After discussion of the possible role of relaxation hypnotherapy in palliative care we decided to offer the therapy to patients who attend the hospice day centre. The increasing popularity of complementary therapies, with unproven claims sometimes being made, had caused concern as several patients had paid for expensive 'therapies' elsewhere and the clinical team received no communication from these therapists. It was felt important that all therapies, both conventional medical and complementary, should be integrated to ensure that important psychosocial information or a changing clinical state was not ignored to the detriment of the patient and family. Other complementary therapies offered at Holme Tower are reflexology, by a visiting registered community nursing sister, and group relaxation sessions, run by the occupational therapist.

The hypnotherapist (OLJ), a retired general practitioner and accredited member of the British Society of Medical and Dental Hypnosis[25], works on a voluntary basis but subject to the same constraints as paid staff. Patients are routinely informed of his background, but are not routinely told he is

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a volunteer unless they ask, lest they should feel obligated for his time and service. Since the weekly service started in June 1993, a total of 156 patients were referred for hypnotherapy, one-third (n=52) men. 121 (78%) had a second treatment session; 93 (60%) had a third treatment session, 21 (13%) had four or more sessions.

All patients at Holme Tower are referred by their GP or hospital consultant for specialist palliative care; day care can take 24 patients per day in total. Hypnotherapy is offered as a therapy option to those day care patients who appear to have specific difficulties with relaxing or coping with their illness or who request hypnotherapy after talking to other patients. The predominant problems presented to the therapist are fears related to the illness and the difficulty of living with uncertainties about the future.

Hypnotherapy sessions are conducted in a room in the day centre where the patient can recline comfortably. An accompanying relative or friend, if present at the request of the patient, is provided with a high-backed comfortable chair; in addition, an independent observer is present at over 80% of sessions. The environment is not particularly quiet, but the sessions are not interrupted. Verbal informed consent is obtained before treatment.

Initially the patient's problems are discussed; the issues to be addressed are agreed with the patient, who is then taught a relaxation routine and self-hypnosis. Some patients discuss important psychosocial matters with the therapist, such as previous wartime or abuse trauma, family conflicts or adverse hospital experiences. This is recorded in the patients' clinical notes with their permission.

The relaxation routine is a modification of the Ellman induction routine followed by progressive relaxation of the body; the trance is deepened by describing a peaceful scene. When family dynamics are strained it can be particularly useful to conduct the hypnotherapy with the spouse present; this allays fears, allows the spouse to prompt the patient later if parts of the relaxation routine have been forgotten, and acts as a form of family therapy as patient and spouse hear the same issues. The third session is tape recorded to summarize all three sessions. After each session the day centre nurse checks how the patient feels; patients often use this opportunity to disclose further fears about their disease.

METHOD

From the 156 hypnotherapy treatment records, 89 patients had died from their cancer; 67 patients were thought to be living. Cross-checking with the hospice computerized database and the patient's GP showed seven had died, four had moved away and four had incomplete addresses. Therefore 52 patients were surveyed, of whom 15 (29%) were men.

A covering letter and a simple unlabelled form were sent to patients, who were invited to append their comments anonymously.

Patients were sent an A4 size sheet which asked:

Following hypnotherapy have you found coping with your illness

1 Unchanged
2 Easier
3 More difficult

(please circle whichever applies)

If you have any other comments, please write them below:

The remainder of the page was left blank for comments.

RESULTS

52 forms were sent out. 44 responses were received but two patients mailed had died and one was abroad. These were excluded from subsequent analysis, so 41 responses (79%) were analysed. There was no significant difference in the median age range of female (56 years; range 39–87) and male (51 years; range 29–74) patients.

One patient reported that coping was 'more difficult' as the previously controlled pain had progressed.

15 patients (37% of respondents) reported coping with their illness as 'unchanged'. One patient had adverse comments, stating that the hypnotherapy was an 'emotionally and physically disturbing experience'. Another preferred physiotherapy and reflexology. One found hypnotherapy 'the same as a relaxation class'; another felt the sessions 'confirmed self-hypnosis' previously learnt, but had hoped for more sessions to 'boost her immune system'. Two patients coped more easily during treatment, but this was not sustained. Two patients felt too ill to benefit, another was unable to relax. Two had found the hypnotherapy pleasurable but nothing more, although one of these patients requested more sessions.

25 patients (61% of respondents) reported coping was 'easier'. Eight spontaneously reported using the audiotapes regularly. 11 noted they had improved coping strategies, including less anxiety (1), coping with panic attacks (1), improved sleeping with decreased use of hypnotics (1), fewer black thoughts (1), and a more positive attitude (2). One patient reported less depression but had been on antidepressants simultaneously. Two patients had felt able to cope with further oncology treatments following the sessions; one reported improved pain control. Three patients had felt less lonely and socially isolated. Six patients wrote messages of gratitude on their forms for the help given.

A total of 35 respondents (85%) appended positive comments about their hypnotherapy even though some of these reported no change in their ability to cope following therapy. Two patients reported it comparable to reflexology

and aromatherapy; one stated it was inferior. Seven respondents requested more sessions.

DISCUSSION

Hypnotherapy had not been offered to all patients attending day care or referred to Holme Tower. It had been offered to a selected group whom the nurses thought likely to benefit, because they exhibit anxiety features and lack of confidence or self-esteem.

A retrospective questionnaire is a crude evaluation. It is likely to elicit positive responses from patients who have received care; they may not differentiate general psychosocial support from specific interventions. Considering these biases, surprisingly few (61%) reported coping better with their illness following hypnotherapy. However, only one patient reported coping less well and two patients in the 'unchanged' group found it an adverse experience; thus 7% are reporting harmful or negative effects from the process. The lack of adverse appended comments may reflect overall gratitude for any help given, irrespective of the type. In this vulnerable group of patients the contact with the therapist or the atmosphere of day care may be as useful as the therapy.

Perhaps the most important finding from our evaluation is that only one in 41 reported a true adverse experience associated with the therapy. Compared with potential complication rates of other treatments such as drugs, this seems low, which adheres well to the ethical principle of non-maleficence in determining interventions. An overall beneficial effect (beneficence) would seem to have occurred in at least 61% of patients surveyed.

The higher number of women in the sample (71%) reflects the overall uptake by women (67%) of our hypnotherapy. Female nurses may discuss fears and anxieties more readily with female patients, or the male patients may be more reticent about emotional difficulties in coping with their illness, despite the therapist being male. In anecdotal evidence from medical hypnotherapy (Hypnosis in Palliative Cancer Management, Meeting of the Section of Hypnosis and Psychosomatic Medicine, Royal Society of Medicine, London, 26 January 1996) both private and NHS sectors report a higher uptake of hypnotherapy by women, of up to 80%.

Unrealistic expectations, as in one respondent, are frequent amongst those cancer patients seeking alternative therapies, such as faith healing or unproven diets. The integration of monitored complementary therapies within the hospice service allows patients to access these whilst protecting vulnerable patients from expensive private alternative therapists who make unsubstantiated claims of remission or cure. Important clinical information can be identified for future care planning of the patient.

CONCLUSION

In a selected group of patients offered hypnotherapy, benefits may include decreased anxiety and increased relaxation. The risk of hypnotherapy being harmful appears small when the principles taught by the British Society of Medical and Dental Hypnosis are adhered to. However, there is a need for an objective prospective evaluation through randomized trials of all non-medical therapies available to patients and to define their roles in supportive care[26].

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